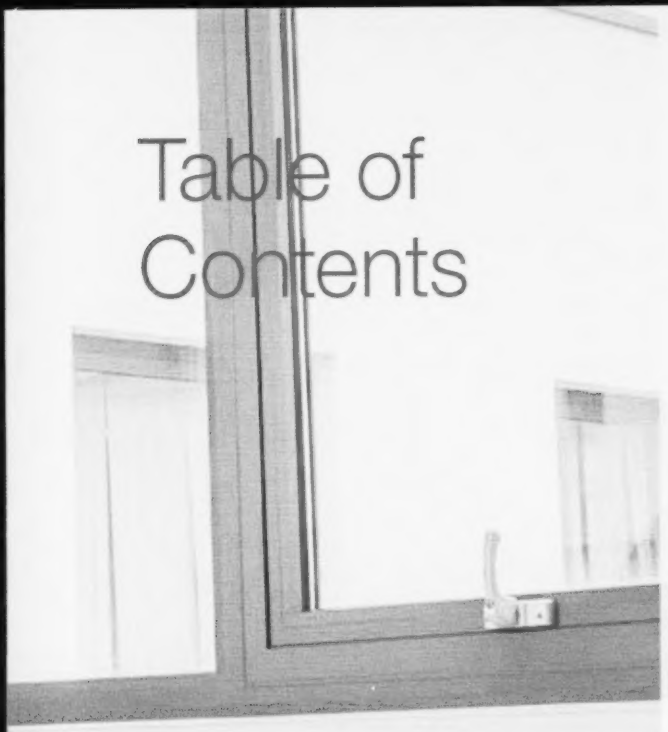
Yearly Report on Ontario's Health System

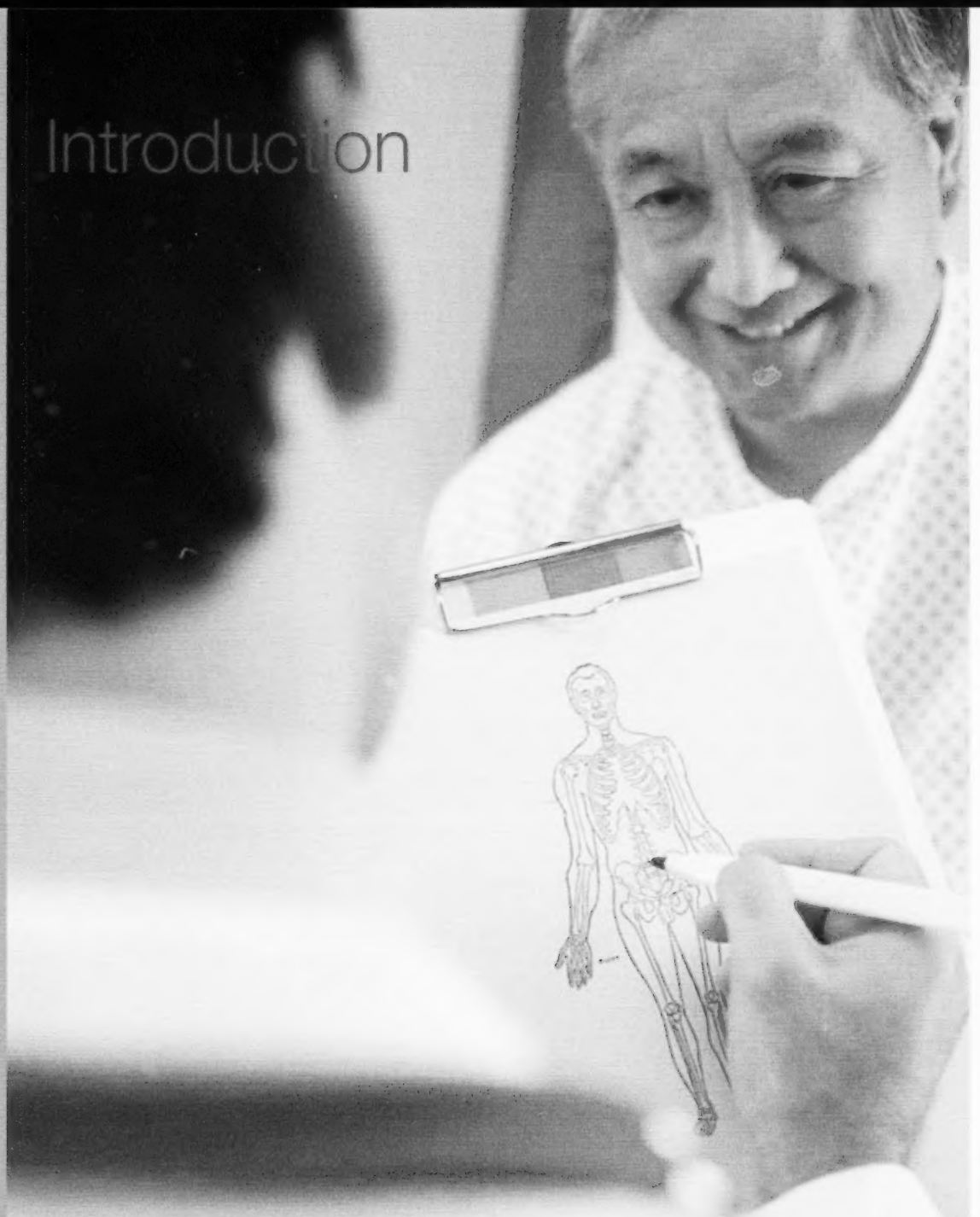
Ontario
Health Quality Ontario


Pathology

Table of Contents



Introduction



Ontarians deserve the best from their health care system. That means care that is accessible, effective, safe, patient-centered, equitable, efficient, appropriate, integrated and focused on population health. We need a health care system committed to delivering the highest quality of care to all Ontarians, now and in the future.

Health Quality Ontario (HQO) plays a key role in realizing that commitment. Fulfilling our mandate under Ontario's *Excellent Care for All Act* (2010), HQO helps maintain transparency and accountability within the Ontario health care system by reporting to Ontarians each year, through vehicles such as this report, on the quality of health services being delivered in the community, hospitals and other facilities, such as long-term care homes.

As part of the *Excellent Care for All Act*, HQO is mandated to report to Ontarians on four areas.

1. ACCESS TO PUBLICLY FUNDED HEALTH SERVICES
2. HEALTH HUMAN RESOURCES IN PUBLICLY FUNDED HEALTH SERVICES
3. CONSUMER AND POPULATION HEALTH STATUS
4. HEALTH SYSTEM OUTCOMES

This yearly report highlights a selected set of performance indicators that reflect successes and areas for improvement within these four key areas.

HQO also seeks to influence the indicators it monitors, through its quality improvement activities, acting as a conduit for the spread of evidence to accelerate knowledge-informed practice. It uses various mechanisms to do so, including its Knowledge Translation Network and knowledge transfer and exchange strategy; an annual conference, Health Quality Transformation, which serves as a platform for knowledge transfer and exchange; and its central repository of tools and resources, such as its Quality Compass, which promotes uptake of best practices.

Evidence has become increasingly important in Ontario's health-policy and decision-making environment. HQO's Evidence Development and Standards branch (EDS) works with clinical experts, scientific collaborators, panels and field evaluation partners to provide evidence about the effectiveness and cost-effectiveness of health technologies and services in Ontario. While EDS develops the evidentiary platform, the Ontario Health Technology Advisory Committee (OHTAC)—a standing advisory sub-committee of the HQO Board—uses this information to make recommendations about the uptake, diffusion, distribution, or removal of health interventions in the province. Using OHTAC's recommendations and advice, the HQO Board provides final recommendations to the health care system and the Minister of Health and Long-Term Care. The OHTAC recommendations and other associated reports can be found at **www.hqontario.ca/evidence/publications-and-ohtac-recommendations**.

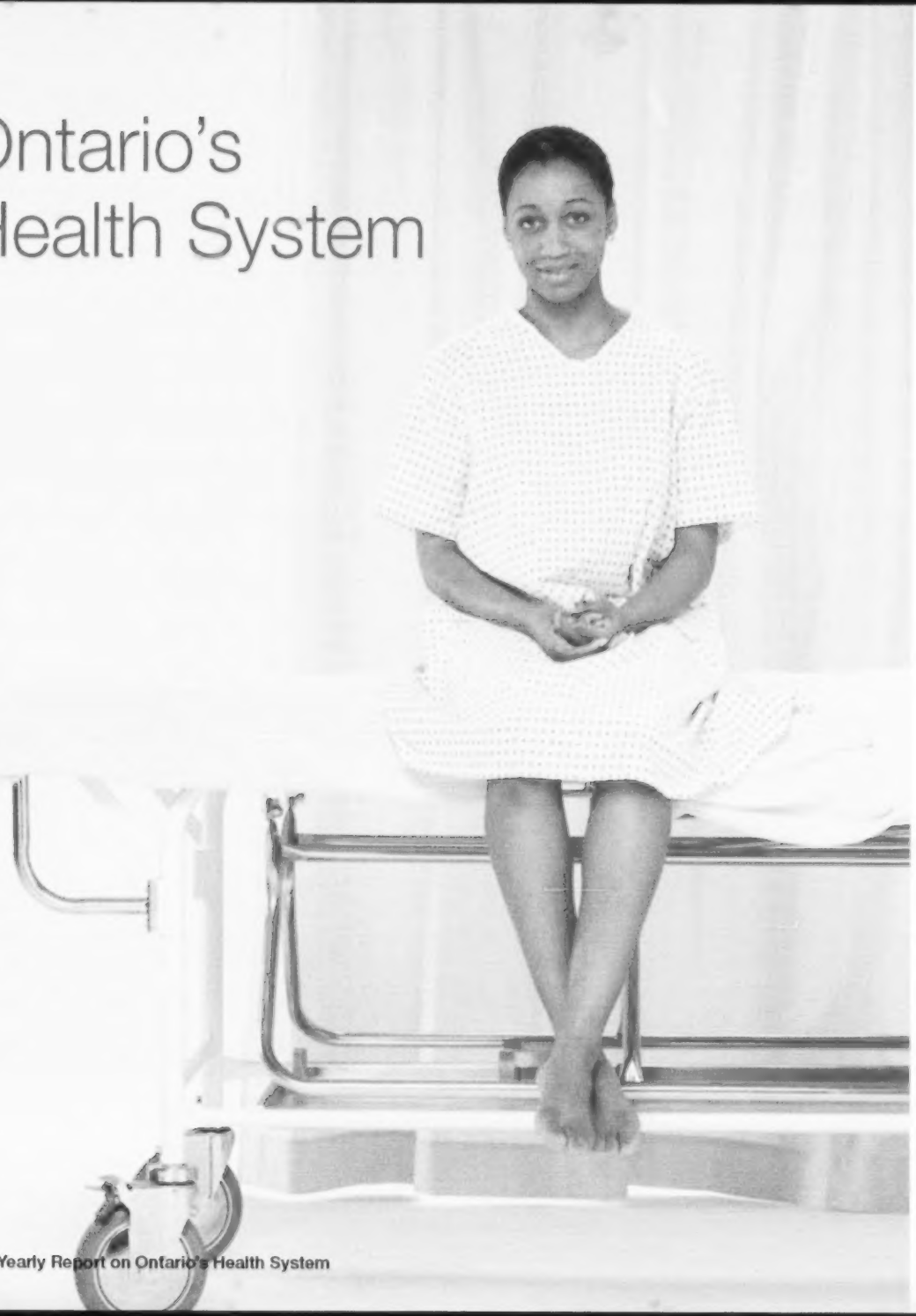
Over the past year alone, HQO has identified $250 million in potential health system savings by highlighting underused, overused or misused practices.

In collaboration with health care system partners, HQO is developing a common quality agenda initiative to better focus on a set of key performance measures. This initiative will identify these measures, report them at the appropriate level, set targets where possible, and work with system partners to support change that will move towards these targets. Indicators in this yearly report align with this initiative.

Over the past year alone, HQO has identified $250 MILLION in potential health system savings

HQO's vision in carrying out these activities is improved health outcomes for Ontarians, greater efficiency, and delivery of health care organized around the patient. The yearly report is complemented and enhanced by other detailed public reporting throughout the year.

Ontario's Health System



Access to publicly funded health services

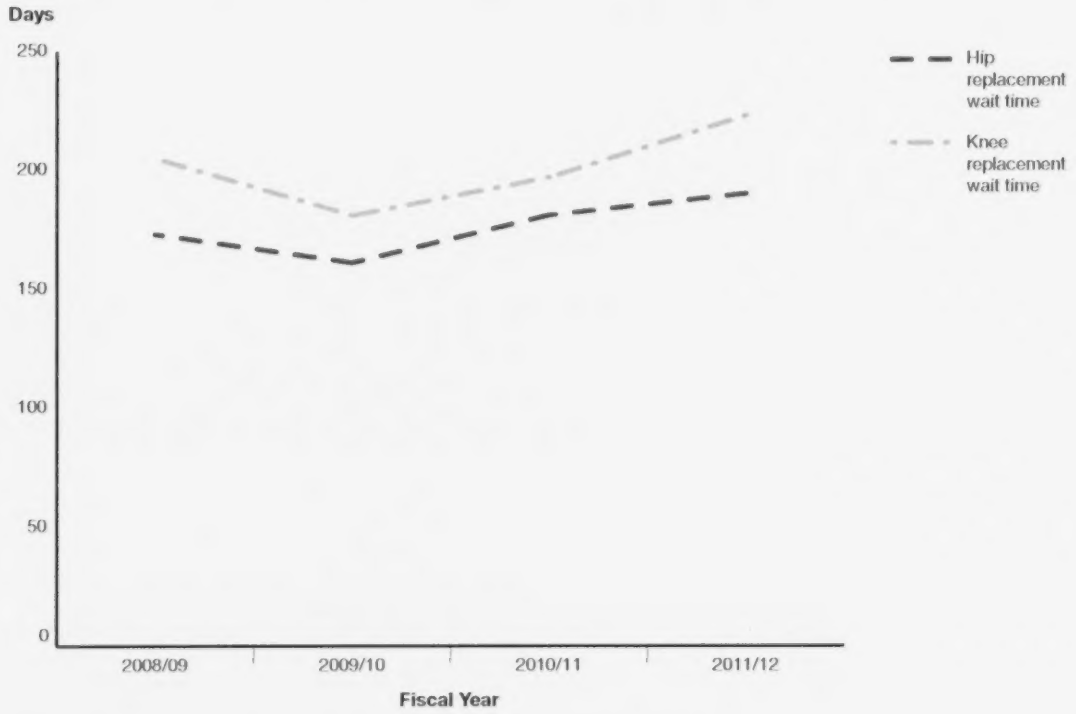
Timely access is a key element of quality across the care continuum. In terms of primary care, it is important to be able to see your primary care provider when needed.[1] Not being able to do so may mean that your health further declines or you may visit an emergency department or a different provider who is unfamiliar with your medical history.[1,2]

> The *Health Care Experience Survey* reported based on data collected between October 2012 and March 2013, that only 43.1% of Ontarians were able to see their primary care providers on the same or next day when sick.[3]

Access to specialist care is measured from the time of referral to specialists until your treatment is completed.[4] The wait times for patients needing elective hip and knee replacements are among the longest for all specialized surgeries for adults.[5] In 2011/12, 90% of elective hip replacement surgeries were completed within 190 days, an increase from 173 days in 2008/09 (**Figure 1**).[6] In 2011/12, 90% of elective knee replacement surgeries were completed within 223 days, an increase from 205 days in 2008/09 (**Figure 1**).[6] From 2010 to 2012, Ontario had the highest proportion of patients receiving hip and knee replacements within the pan-Canadian benchmark of 26 weeks of all provinces.[7]

43.1% of Ontarians were able to see their primary care providers on the **SAME OR NEXT DAY** when sick

FIGURE 1 90th percentile wait times for hip and knee replacements*

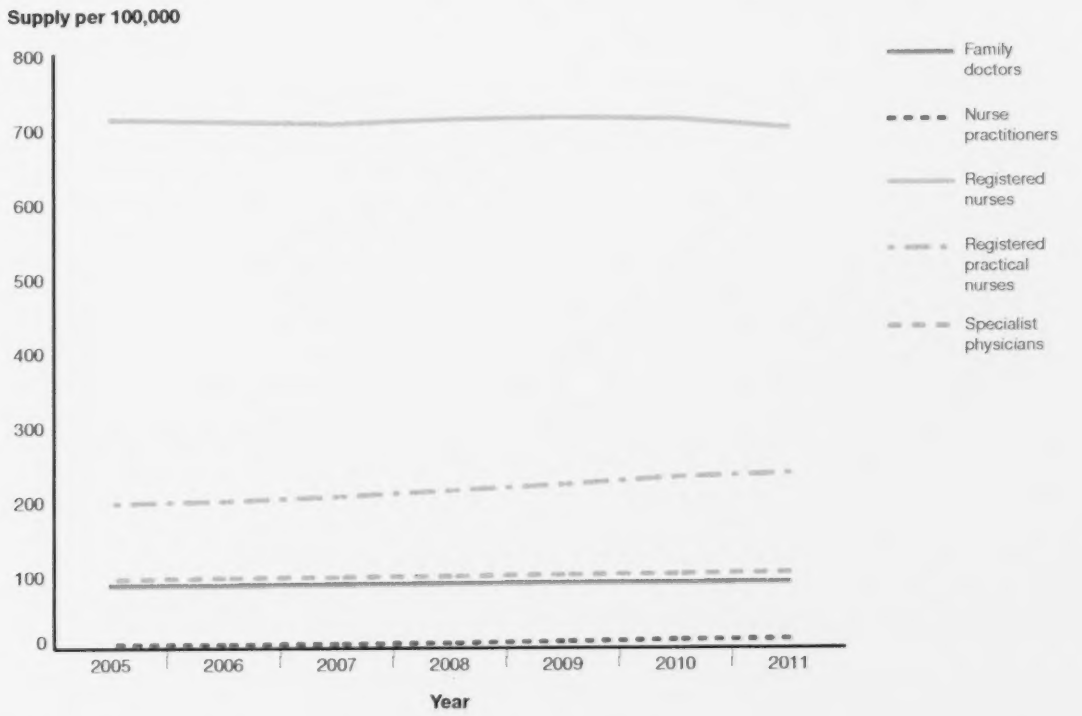


2008/09–2011/12. Source: Wait Times Information System (WTIS), Cancer Care Ontario (CCO)
**Please note that only priority level 2,3, and 4 cases are included*

Health human resources in publicly funded health services

From 2005 to 2011, the number of physicians and nurses have either remained stable or increased in Ontario (**Figure 2**).[8] The greatest relative increase was observed for nurse practitioners. The number of nurse practitioners increased almost threefold (4.8 to 12.4) from 2005 to 2011 (**Figure 2**).[8]

FIGURE 2 Supply per 100,000 people of doctors and nurses



2005 to 2011. Source: Ontario Physician Human Resources Data Centre (OPHRDC), College of Nurses Ontario (CNO)

Consumer and population health status

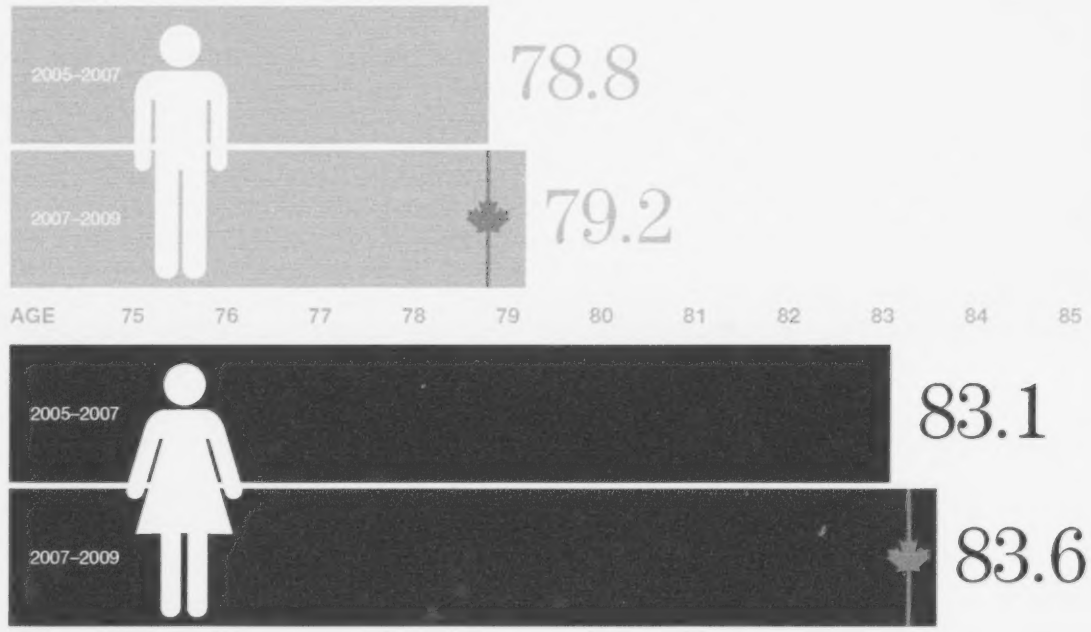
Perhaps the most important goals for Ontario's health care system relate to improving consumer and population health status and ensuring equitable delivery of care.[9] Every Ontarian deserves to lead a long, healthy and productive life. A high-quality health care system that takes into account social determinants of health, such as income and education, as well as health inequities in planning and delivery of services will help ensure that each Ontarian has the best possible chance of realizing this ambition.[10]

Life expectancy and infant mortality are two important and internationally recognized measures used to gauge the overall health of a population and the effectiveness of the health care system.

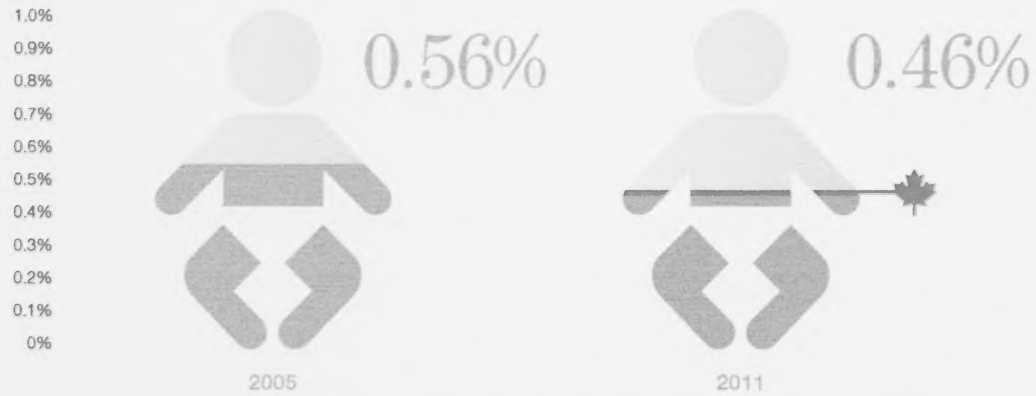
Life expectancy at birth (the number of years a newborn infant would be expected to live on average if current death rates were to remain constant)[11] was 78.8 years for males in Ontario and 83.1 years for females during 2005-07.[12] In 2007-09, life expectancy at birth for males was 79.2 years and 83.6 years for females, a slight increase.[12] In 2007-09, the Canadian average life expectancy at birth was 78.8 years and 83.3 for males and females, respectively.[13]

Life expectancy at birth is strongly influenced by infant mortality, or the number of deaths among live-born infants during the first year of life.[14] Infant mortality is a key indicator of maternal and child well-being, including health and nutritional status.[15]

The infant mortality rate in Ontario has decreased from 5.6 deaths per 1,000 births in 2005 to 4.6 in 2011, slightly lower than the Canadian average of 4.8 per 1,000 births that same year.[16]



LIFE EXPECTANCY at birth in Ontario has increased slightly for both males and females, and is higher than the Canadian average



INFANT MORTALITY RATE in Ontario has decreased, and is slightly lower than the Canadian average

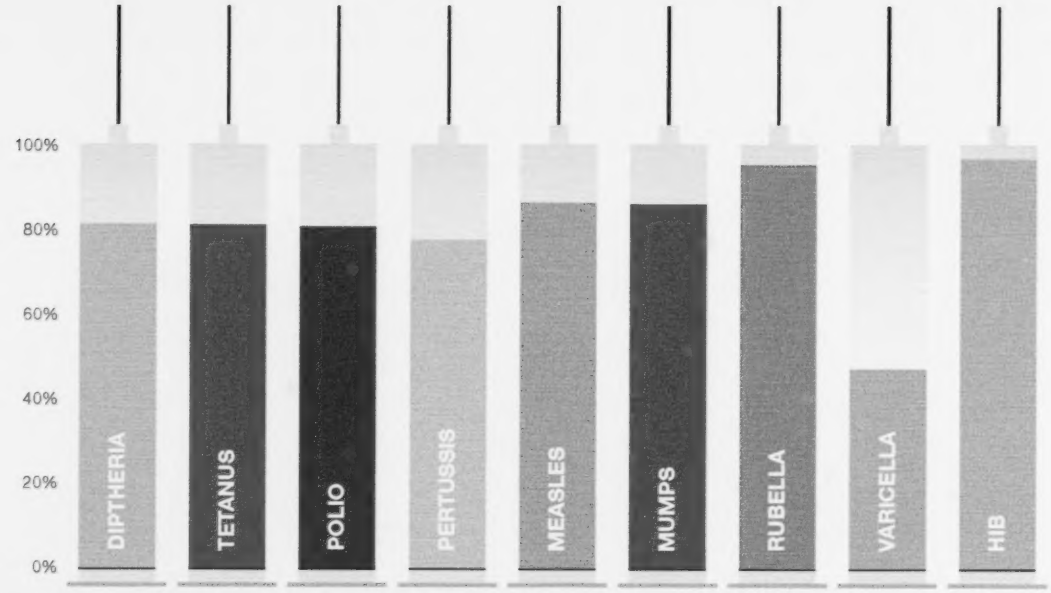
Many infectious diseases, including some that are potentially fatal, can be prevented with vaccination.[17] Ontario continues to achieve relatively high coverage rates for childhood vaccines.[18]

Provincial estimates (based on public health unit data) for nine of Ontario's 14 publicly funded immunizations show that the coverage rate for seven-year-olds during the 2010/11 school year varied by vaccine, from a high of 95% for rubella to a low of 77.4% for pertussis, or whooping cough.[17] Among vaccines that are provincially funded but not required for school attendance, coverage was lowest for varicella, or chicken pox, (47.2%) and highest for Haemophilus influenzae type b (Hib) vaccines (96.6%).[17]

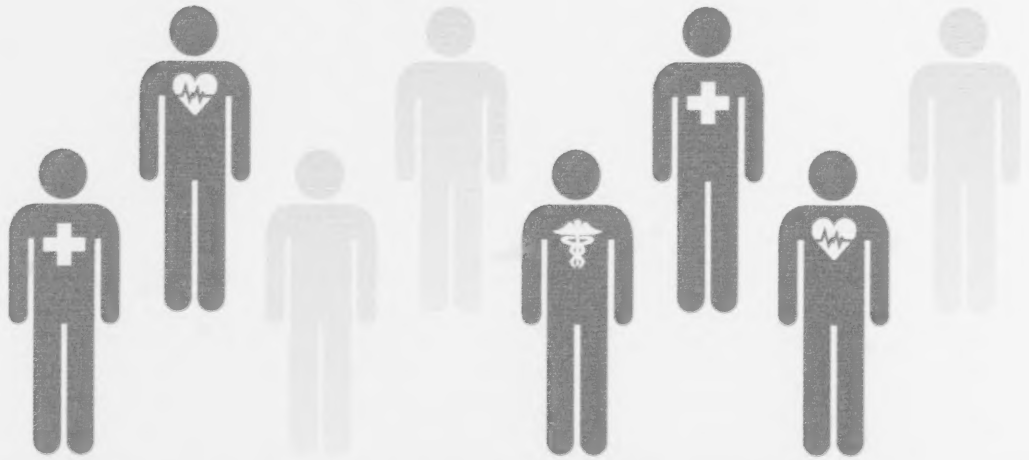
Another way of examining the health status of a population is to look at the prevalence of various chronic diseases, as well as our ability to successfully manage these conditions.

More than half (63%) of Ontarians are affected by a chronic condition such as diabetes, high blood pressure or depression.[19]

While there has been some progress in the management of such diseases, there is still much room for improvement, as people are not routinely receiving all of the evidence-based best practices in chronic disease management that could maintain their health.



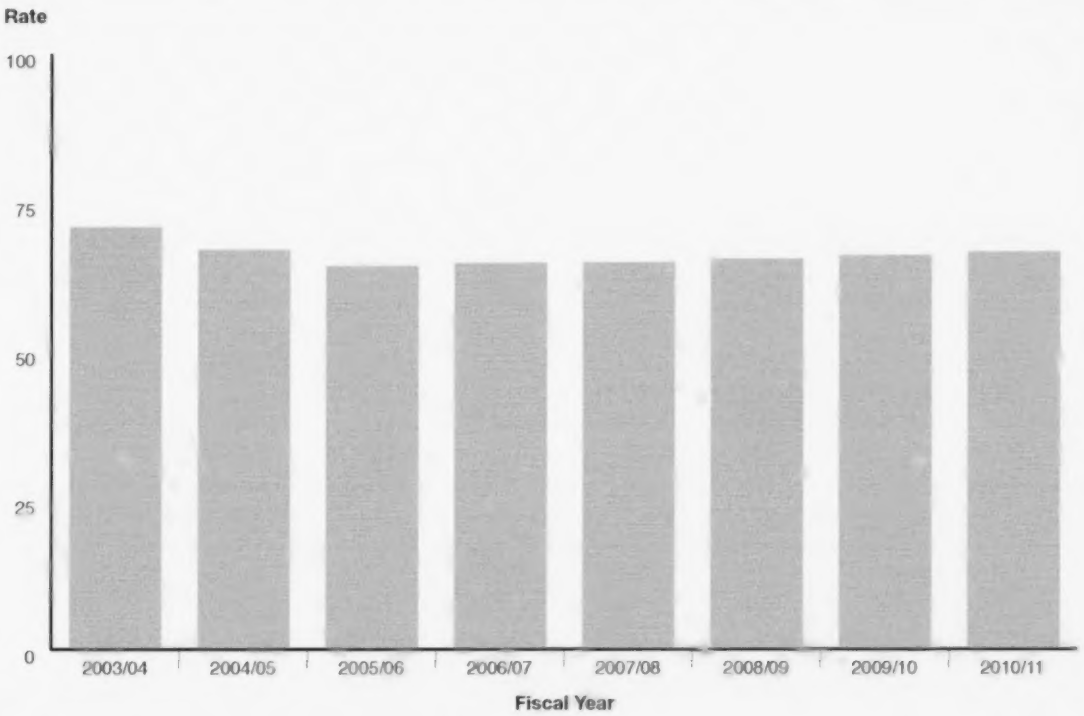
Coverage rate for Ontario's publicly-funded **IMMUNIZATIONS** varied by vaccine



More than half (63%) of Ontarians are affected by one or more **CHRONIC CONDITIONS**

In 2010/11, for instance, two-thirds (66%) of Ontarians with diabetes received screening for diabetic retinopathy within a two-year period, a decrease from the 71% who received the screening in 2003/04 (**Figure 3**).[20] Routine screening, referral and treatment for diabetic retinopathy can significantly reduce the onset of blindness and prevent or delay vision loss.[21] Clinical practice guidelines recommend screening for retinopathy in patients with type 2 diabetes every one to two years, with the interval for follow-up tailored to the severity of the retinopathy.[22]

FIGURE 3 Rates (per 100) of Ontarians with diabetes who had an eye test within two years



2003/04–2010/11. Source: Institute for Clinical Evaluative Sciences (ICES)

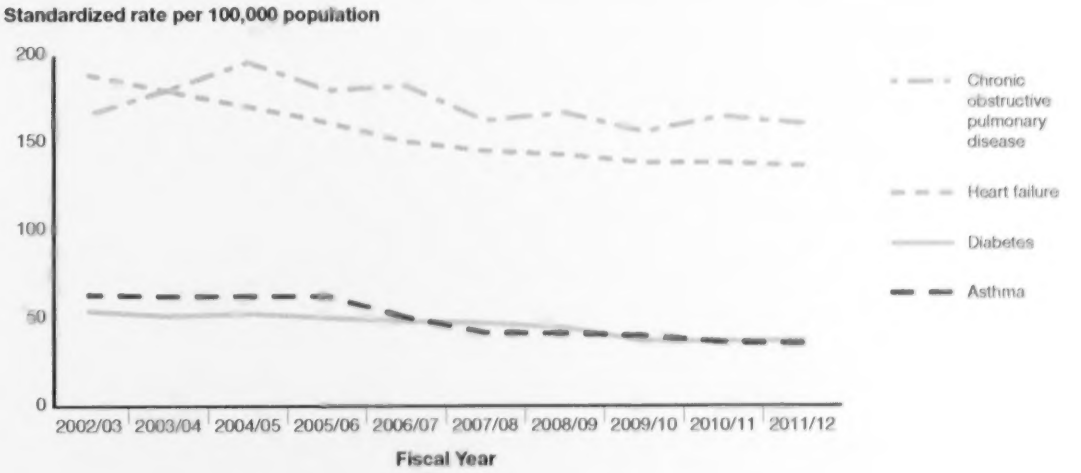
Health system outcomes and integration

Health system outcomes refer to the goals of health systems, including improvements in the health of the population, the ability of the system to respond to the needs and demands of, in this case, Ontarians and the value received for the money invested (and thus the sustainability and integration of the system).[23] These outcomes encompass continuity of care for people with chronic diseases and rates of hospitalization for diseases that could be treated in the community.

Ensuring integrated and coordinated care for people with chronic diseases, across programs, practitioners, organizations and levels of care, is essential to minimizing unnecessary emergency department visits, avoiding hospitalizations and re-admissions and ensuring the best possible health outcomes.[1,2] This is particularly true for adults with more than one chronic disease, who are often seen by a variety of health care providers in a number of different settings.

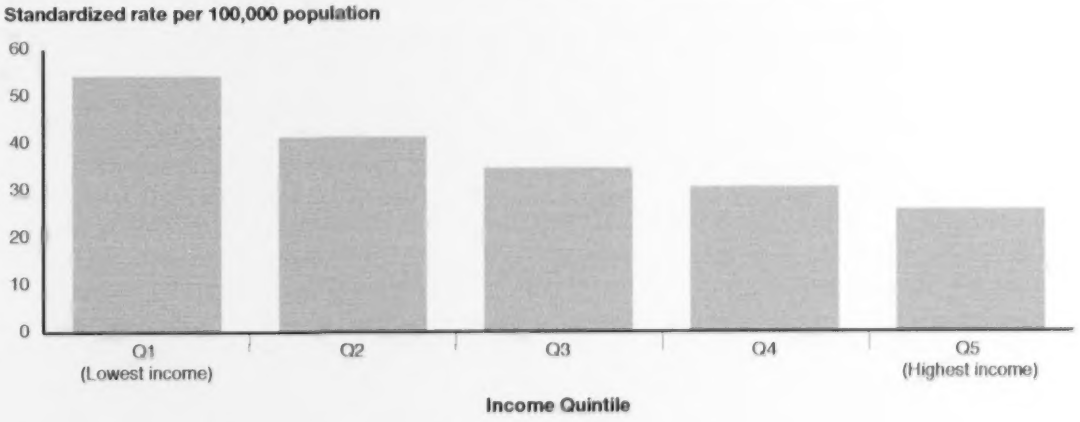
Examining hospitalization rates for conditions that can be managed in the community such as asthma, heart failure, diabetes or chronic obstructive pulmonary disease, is one way to measure the performance of the health care system.[1,2] Since 2002/03, there has been a steady decline for three out of the four conditions (heart failure, diabetes and asthma) and an overall decline for chronic obstructive pulmonary disease in the last ten years (**Figure 4**).[24] Hospitalization rates are highest among people living in the lowest-income neighbourhoods, particularly for those with diabetes (**Figure 5**) and chronic obstructive pulmonary disease.[24] Self-management education programs for people living in low-income neighbourhoods and extended primary care office hours (e.g., evenings and weekend) can help address disparities for lower-

FIGURE 4 Age- and sex-standardized hospitalization rate for four conditions



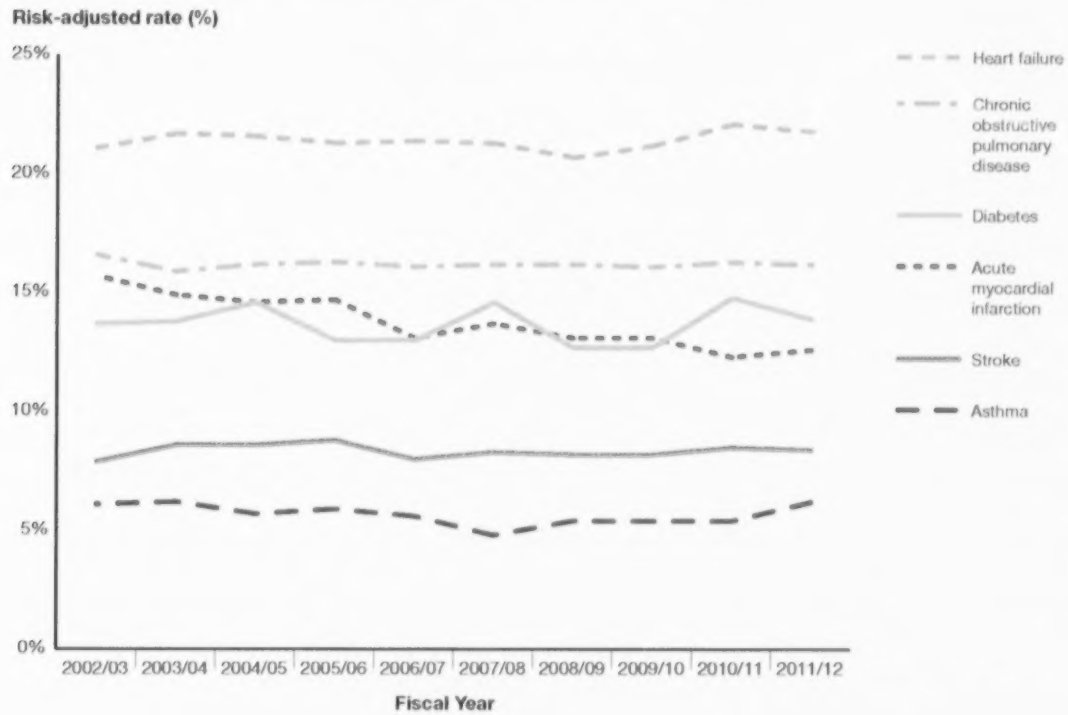
Ontario, 2002/03–2011/12. Source: Institute for Clinical Evaluative Sciences (ICES)

FIGURE 5 Age- and sex-standardized hospitalization rate for diabetes by income quintile



Ontario, 2011/12. Source: Institute for Clinical Evaluative Sciences (ICES)

FIGURE 6 30-day all causes risk-adjusted re-admission rate after an admission for six conditions

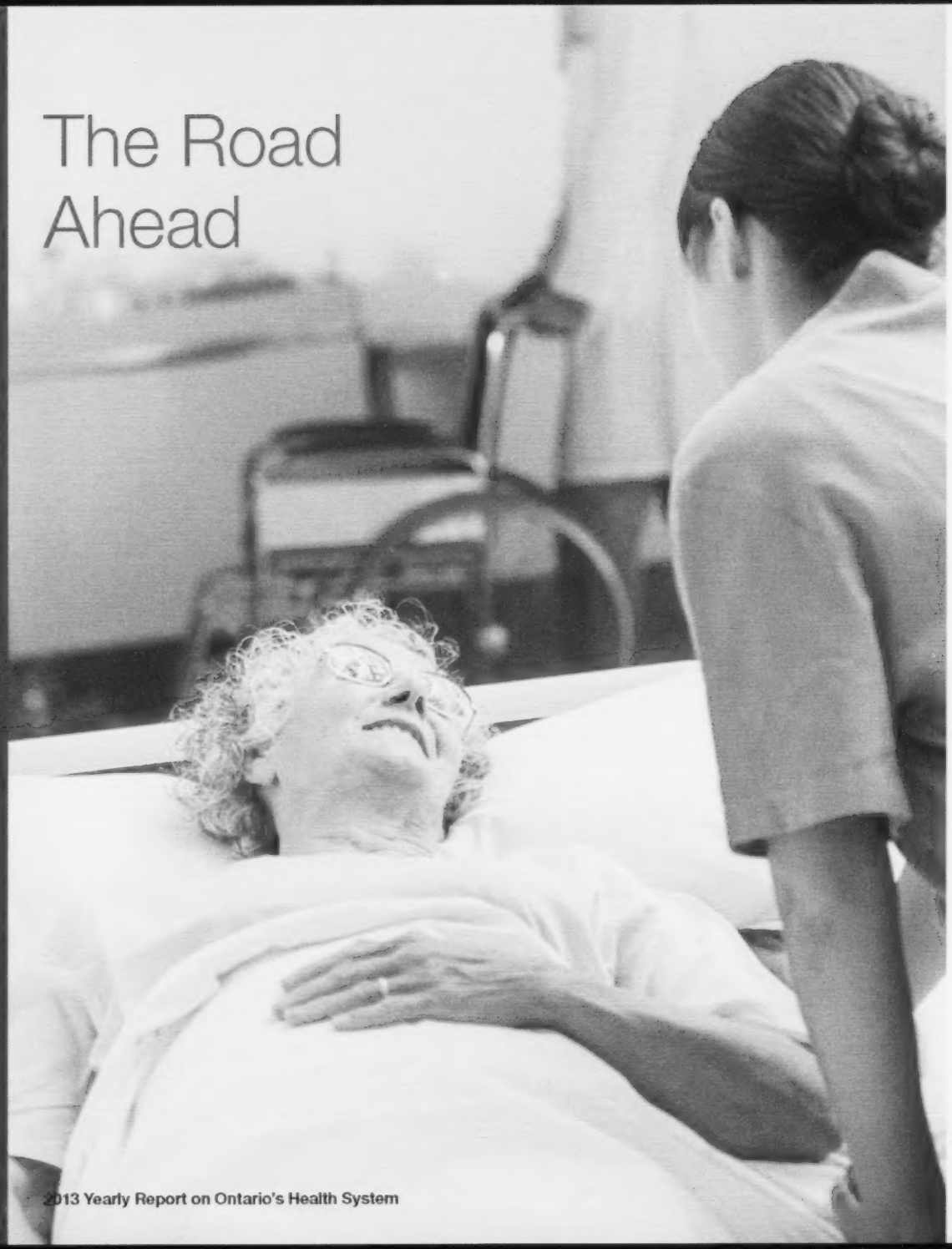


Ontario, 2002/03–2011/12. Source: Institute for Clinical Evaluative Sciences (ICES)

income patients who could not otherwise access these programs and services.[25]

Another measure of the success of integrated and coordinated care is hospital re-admissions after discharge from hospital, as re-admissions that occur within a short period may signal problems in the coordination of care.[1,2] Over the last ten years, there has been little variation in re-admission rates for heart failure, chronic obstructive pulmonary disease, diabetes, acute myocardial infarction, stoke and asthma (**Figure 6**).[26] Heart failure and chronic obstructive pulmonary disease are the two conditions with the largest proportion of patients being re-admitted to any facility for any reason within 30 days of discharge (**Figure 6**).[26] Some re-admissions are necessary, while others may be the result of insufficiencies in care, such as inadequate support for patients as they transition from hospital to a less-intense care setting.[1] Managing chronic conditions better through effective discharge practices, coordinated care transitions and comprehensive primary care services and supports,[2] may reduce the number of preventable hospital re-admissions.

The Road Ahead



As this and HQO's previous yearly reports have demonstrated, the health status of Ontarians continues to improve. However, the reports also demonstrate that there are many opportunities to improve the quality of health care that Ontarians receive.

Accurate and easily available information is important to realizing these opportunities. This information can be used to inform and focus strategies to improve care. HQO is currently developing a new strategy for measuring and reporting health system performance. In creating this strategy, HQO will be undertaking a comprehensive review and consultation process. This process will involve not only health care providers but also patient groups and the broader public. The review will look at the varied needs for data and information across the system and consider how, when and through which media people learn best. In addition to reporting on health system performance in new areas, HQO will continue to report on indicators that capture the four mandated areas represented in this yearly report. Increasingly, HQO will also aim to compare performance with other provinces and countries. New reporting products will also be developed to meet the needs of front-line providers, health system leaders and those individuals who are actively leading the process of quality improvement.

Through partnership with the public, health care systems providers and system leaders, HQO's work can lead to meaningful and positive change for the health care system, supporting the achievement of "excellent care for all" for generations to come.

References

1. Coleman EA. Falling through the cracks: challenges and opportunities for improving transitional care for persons with continuous complex care needs. Journal of American Geriatric Society. 2003; 51 (4): 549-555. **http://www.ncbi.nlm.nih.gov/pubmed/12657078**

2. Jweinat JJ. Hospital readmissions under the spotlight. Journal of Healthcare Management. 2010; 55(4):252–64.

3. Ministry of Health and Long-Term Care. Surveying the Facts about Primary Care. Finding from the Health Care Experience Survey: Same day and next day access. Health Analytics Branch, Health System Information Management and Investment Division. 2013 August; unpublished.

4. Ministry of Health and Long-Term Care. Ontario Wait Times [Internet]. Unknown [cited 7 Aug 2013]. Available from: **http://www.health.gov.on.ca/en/public/programs/waittimes/surgery/faq.aspx**

5. Canadian Institute for Health Information (CIHI). Wait Times in Canada – A Summary, 2012. Ottawa: CIHI; 2012.

6. Wait Times Information System (WTIS), Cancer Care Ontario (CCO).

7. Health Council of Canada. Progress Report 2013: Health Care Renewal in Canada. Toronto: Health Council of Canada; 2013.

8. Ontario Physician Human Resources Data Centre (OPHRDC), College of Nurses Ontario (CNO)

9. Public Health Agency of Canada. What is the Population Health Approach? [Internet]. 2012 February; [cited 6 Aug 2013]. Available from: **http://www.phac-aspc.gc.ca/ph-sp/approach-approche/index-eng.php**

10. Murray CJL, Salomon JA, Mathers C. A Critical Examination of Summary Measures of Population Health [Internet]. [cited 6 Aug 2013]. Available from: **http://www.who.int/healthinfo/paper02.pdf**

11. Colman R. A Profile of Women's Health Indicators in Canada — Prepared for the Women's Health Bureau, Health Canada [Internet]. 2003 July; [cited 6 Aug 2013]. Available from: **http://www.gpiatlantic.org/pdf/health/womens/whbreport.pdf**

12. Statistics Canada. Life expectancy at birth, by sex, by province [Internet]. 2012 May; [cited 6 Aug 2013]. Available from: **http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/health26-eng.htm**

13. Statistics Canada. Life Tables, Canada, Provinces and Territories 2007 to 2009 [Internet]. ; 2013 March; [cited 6 Aug 2013 August 6]. Available from: **http://www.statcan.gc.ca/pub/84-537-x/84-537-x2013003-eng.htm**

14. Toronto Public Health. Toronto's Health Status Indicator Series: Infant Mortality [Internet]. Available from: **https://www1.toronto.ca/staticfiles/city_of_toronto/toronto_public_health/performance__standards/map/files/pdf/infantmortality.pdf**

15. World Health Organization. Understanding Maternal, Newborn and Child Health: Understanding Key Program Indicators. [Internet]. 2011; [cited 6 Aug 2013]. Available from: **http://www.who.int/healthmetrics/news/monitoring_maternal_newborn_child_health.pdf**

16. Statistics Canada. Table 102-0504. Deaths and mortality rates, by age group and sex, Canada, provinces and territories [Internet]. 2012 May; [cited 6 Aug 2013]. Available from: **http://www5.statcan.gc.ca/cansim/a26?lang=eng&retrLang=eng&id=1020504&paSer=&pattern=&stByVal=1&p1=1&p2=37&tabMode=dataTable&csid=**

17. Association of Public Health Epidemiologists in Ontario. Childhood Vaccination Coverage [Internet]. 2011; [cited 6 Aug 2013]. Available from: **http://www.apheo.ca/index.php?pid=168**

18. Ministry of Health and Long-Term Care. Immunization is the Foundation for a Healthy Life [Internet]. Unknown [cited 7 Aug 2013]. Available from: **http://www.health.gov.on.ca/en/public/programs/immunization/resources.aspx**

19. Health Council of Canada. Where You Live Matters: Canadian Views on Health Care Quality – Results from the Commonwealth Fund International Health Policy Survey of the General Public. Health Council of Canada. 2013 October; unpublished.

20. Institute for Clinical Evaluative Sciences (ICES).

21. Diabetes Task Force. Report to the Ministry of Health and Long-Term Care. September 2004.

22. Clinical Practice Guidelines 2013. Published by the Canadian Diabetes Association. Available from: **http://guidelines.diabetes.ca/Browse/Chapter3**

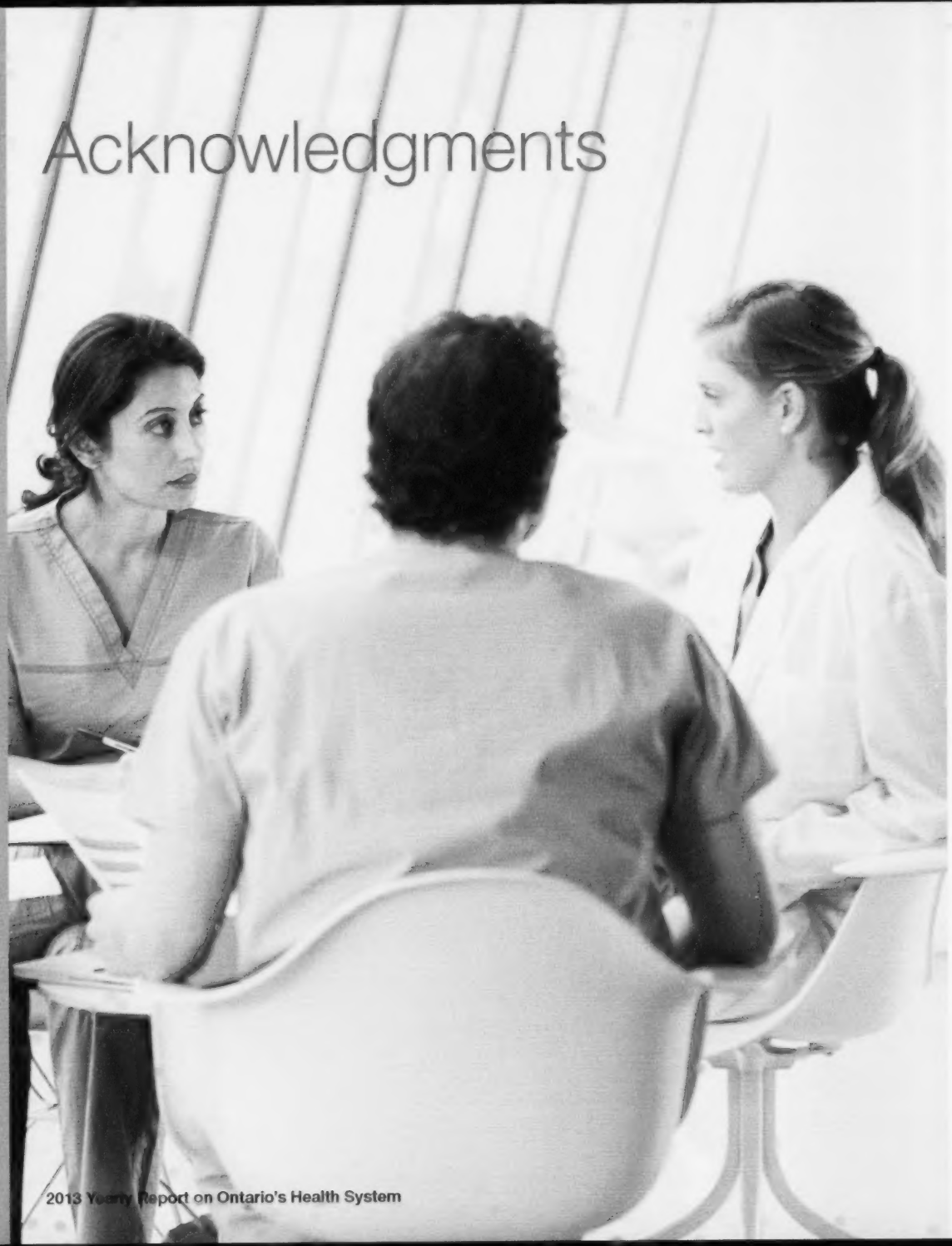
23. Canadian Institute for Health Information (CIHI). A Performance Measurement Framework. Ottawa: CIHI; 2013.

24. Institute for Clinical Evaluative Sciences (ICES).

25. Cauch-Dudek K, Victor JC, Sigmond M, Shah BR. Disparities in attendance of diabetes self-management education programs after diagnosis in Ontario, Canada: a cohort study. BMC Public Health. 2013; 13(85). Available from: **http://www.biomedcentral.com/1471-2458/13/85**

26. Institute for Clinical Evaluative Sciences (ICES).

Acknowledgments



Health Quality Ontario would like to acknowledge and thank all of our partners who supported the production of this yearly report by providing data and reviewing content.

Health Quality Ontario

BOARD

Dr. Andreas Laupacis Chair

Ms. Marie E. Fortier Vice-Chair

Mr. Richard Alvarez

Dr. Andy Molino

Dr. Tazim Virani

Dr. Faith Donald

Mr. Tom Closson

Dr. Jeremy M. Grimshaw

Mr. James Morrisey

Biographies are posted at
www.hqontario.ca/about-us/governance

MANAGEMENT

Dr. Joshua Tepper President and
Chief Executive Officer

Dr. Les Levin Vice President,
Evidence Development and Standards

Ms. Mary Kardos Burton Interim Vice President,
Integrated Program Delivery

Dr. Irfan Dhalla Interim Vice President,
Health System Performance

MANDATE

Health Quality Ontario (HQO) is a government agency, created under the *Commitment to the Future of Medicare Act* on September 12, 2005.

In June 2008, the Ontario government tasked HQO with measuring and reporting to the public on the quality of long-term care and resident satisfaction. In December 2008, HQO was tasked with measuring and reporting to the public on the quality of home care services and client satisfaction with these services.

On June 8, 2010, the *Excellent Care for All Act* was passed in the legislature expanding HQO's role and mandate. The functions of HQO are:

a) to monitor and report to the people of Ontario on,

   i. access to publicly funded health services,

   ii. health human resources in publicly funded health services,

   iii. consumer and population health status, and

   iv. health system outcomes;

b) to support continuous quality improvement;

c) to promote health care that is supported by the best available scientific evidence by,

   i. making recommendations to health care organizations and other entities on standards of care in the health system, based on or respecting clinical practice guidelines and protocols, and

   ii. making recommendations, based on evidence and with consideration of the recommendations in subclause (i), to the Minister concerning the Government of Ontario's provision of funding for health care services and medical devices

Section 5 of the Act requires HQO to deliver a yearly report to the Minister on the state of the health system in Ontario, and any other reports required by the Minister.

ISSN 2292-2997 (Print)
ISBN 978-1-4606-3246-8 (Print)
ISSN 2292-3075 (Online)
ISBN 978-1-4606-3247-5 (HTML)
ISSN 2292-2075 (Online)
ISBN 978-1-4606-3248-2 (PDF)

Health Quality Ontario
130 Bloor Street West
10th Floor
Toronto, ON M5S 1N5

Telephone: 416-323-6868
Toll-free: 1-866-623-6868
Email: info@hqontario.ca
www.hqontario.ca

Ontario
Health Quality Ontario